

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395101	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/19/2025
NAME OF PROVIDER OR SUPPLIER: SAYRE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 151 KEEFER LANE SAYRE, PA 18840		
STATE LICENSE NUMBER: 192102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on March 19, 2025, at Sayre Health Care Center, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73	E 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

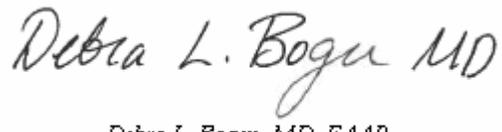


Certified End Page

SAYRE HEALTH CARE CENTER
STATE LICENSE NUMBER: 192102
SURVEY EXIT DATE: 03/19/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

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K 0000	<p>INITIAL COMMENT</p> <p>Facility ID# 192102 Component 10 Replacement Facility</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on March 19, 2025, it was determined that Sayre Health Care Center was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.70(a).</p> <p>This is a one story, Type V (111), protected, wood-frame structure, with unused attic spaces, that is fully sprinklered.</p>	K 0000		

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K 0223 SS=E	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by:	K 0223	-The Maintenance Director promptly took out the rubber wedge and closed the door to the dry food storage room. -The facility Administrator educated both the Maintenance Director and the Food Service Director that, in accordance with life safety regulations, this door must never be propped open. -To ensure compliance, the Maintenance Director will conduct weekly audits for a duration of four weeks, followed by monthly audits for three months, to verify that the dry food storage room door remains closed. The findings from these audits will be presented at the monthly Quality Assurance meeting for evaluation.	Completion Date: 03/31/2025 Status: APPROVED Date: 03/27/2025

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K 0223 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to maintain one door with self-closing devices, affecting one of eight smoke compartments. Findings include: 1. Observation on March 19, 2025, at 10:48 a.m., revealed Dietary, Dry storage door was being held open by unapproved means. (rubber wedge). Exit interview with the Facility Administrator and Facility Maintenance on March 19, 2025, at 11:45 a.m., confirmed the door was being held open.	K 0223		
K 0324 SS=E		K 0324		

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K 0324 SS=E	Continued from page 3 NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by:	K 0324	- The Maintenance Director closed the door to the dry food storage area to ensure the ansul system was unobstructed without delay. - Both the Maintenance Director and the Food Services Director received training on the importance of keeping the ansul system clear in accordance with life safety regulations and compliance standards. - The Maintenance Director will conduct weekly audits for a duration of four weeks, followed by monthly audits for an additional three months, to verify that the ansul system remains unblocked. These audit results will be presented at the QA meeting for evaluation.	Completion Date: 03/31/2025 Status: APPROVED Date: 03/27/2025

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K 0324 SS=E	Continued from page 4 Based on observation and interview, it was determined the facility failed to protect cooking facilities in one location, affecting one of one floors. Findings include: 1. Observation on March 19, 2025, at 10:49 a.m., revealed Dietary, Dry storage door was held open blocking the manual pull station for the ansul system. Exit interview with the Facility Administrator and Facility Maintenance on March 19, 2025, at 11:45 a.m., confirmed the ansul manual pull station being blocked.	K 0324		
K 0353 SS=E		K 0353		

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K 0353 SS=E	Continued from page 5 NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353	- The Maintenance Director has cleaned the dust from the sprinkler heads situated in the 200 hallway by resident room 201, the 300 hallway by resident room 303, and the 400 hallway by resident room 407. - The facility Administrator provided training to both the Maintenance Director and the Environmental Services Director on the importance of keeping these sprinkler heads dust-free at all times. - The Maintenance Director will conduct weekly audits for a duration of four weeks, followed by monthly audits for four months, and will present the findings at the monthly Quality Assurance meeting for evaluation	Completion Date: 03/31/2025 Status: APPROVED Date: 03/27/2025
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K 0353 SS=E	Continued from page 6 Based on observation and interview, it was determined the facility failed to maintain automatic sprinkler systems in three locations, affecting three of eight smoke compartments. Findings include: 1. Observation on March 19, 2025, between 10:58 a.m., and 11:25 a.m., revealed the following sprinkler heads were loaded with dust. a. At 10:58 a.m., 200 Hall, corridor sprinkler head near Resident Room 201. b. At 11:02 a.m., 300 Hall, corridor sprinkler head near Resident Room 303. c. At 11:25 a.m., 400 Hall, corridor sprinkler head near Resident Room 407. Exit interview with the Facility Administrator and Facility Maintenance on March 19, 2025, at 11:45 a.m., confirmed the sprinkler heads loaded with dust.	K 0353		

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K 0355 SS=D	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by:	K 0355	- The Maintenance Director conducted an inspection of the fire extinguisher situated in the mechanical room along the 300 hallway. - The Facility Administrator provided guidance to the Maintenance Director regarding the necessity of verifying that each fire extinguisher is inspected and documented on a monthly basis. - The Maintenance Director is responsible for performing monthly audits and presenting the findings at the Quality Assurance meeting monthly for four months.	Completion Date: 03/31/2025 Status: APPROVED Date: 03/27/2025

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K 0355 SS=D	Continued from page 8 Based on observation and interview, it was determined the facility failed to maintain portable fire extinguishers, affecting one of approximately twenty-five fire extinguishers. Findings include: 1. Observation on March 19, 2025, at 11:22 a.m., 300 Hall, revealed the fire extinguisher located in the Mechanical Room, lacked monthly inspections since the annual maintenance in November of 2024. Exit interview with the Facility Administrator and Facility Maintenance on March 19, 2025, at 11:45 a.m., confirmed the lack of the monthly inspections.	K 0355		
K 0374 SS=E		K 0374		

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K 0374 SS=E	Continued from page 9 NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by:	K 0374	- The Maintenance Director promptly modified the fire barrier door situated between the 300 and 500 areas to guarantee it latches correctly. - The Maintenance Director received education from the facility administrator regarding the inspection of all smoke barrier doors to confirm their proper latching. - The Maintenance Director will conduct weekly random audits of the smoke barrier doors for a duration of four weeks, followed by monthly audits for three months, and will present the findings at the monthly Quality Assurance meeting for evaluation.	Completion Date: 03/31/2025 Status: APPROVED Date: 03/27/2025

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K 0374 SS=E	Continued from page 10 Based on observation and interview, it was determined the facility failed to maintain one set of smoke barrier doors, affecting two of eight smoke compartments. Findings include: 1. Observation on March 19, 2025, at 11:05 a.m., revealed the smoke barrier doors leading from 300 Hall into 500 Hall, needs adjustment to positive latch into corresponding frame. (Left Leaf). Exit interview with the Facility Administrator and Facility Maintenance on March 19, 2025, at 11:45 a.m., confirmed the doors failed to latch into frame.	K 0374		



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